STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-05

Patient Protection and Affordable Care Act policy filing guidelines
Issued Sept. 23, 2010

To: All insurers authorized to conduct health insurance business in Missouri

From: John M. Huff, Director

Re: Patient Protection and Affordable Care Act policy filing guidelines

The federal Patient Protection and Affordable Care Act (PPACA) requires that health policies issued or renewed after Sept. 23, 2010, contain specific provisions regarding benefits and coverage. Plans in effect prior to March 23, 2010, (grandfathered plans) are also required to include some, but not all, of the required provisions after Sept. 23, 2010. The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) has worked with carriers to implement the PPACA's changes and issues this bulletin to remind carriers of their responsibility to file amendments to their health insurance policy forms to ensure compliance with PPACA standards and to outline the DIFP's requirements for filing revisions relating to PPACA.

Grandfathered health plans

A grandfathered health plan is an existing group health plan, including self-insured plans, or individual health insurance coverage that had at least one enrollee as of March 23, 2010. Although many effective dates are delayed for grandfathered group and individual health plans, PPACA requires grandfathered plans to comply with the following provisions for plan years beginning on or after Sept. 23, 2010:

- Prohibition on lifetime limits for essential health benefits
- Prohibition on rescissions
- Extension of coverage for dependents if the adult child is not eligible for employment-based health benefits
- Grandfathered group health plans will also be required to comply with annual limits on essential health benefits and pre-existing condition exclusions for children 19 years of age or younger

Exhibit 1

No lifetime limits

Group health and individual health plans may not contain lifetime limits on the dollar value of essential health benefits. Essential benefit categories are provided later in this bulletin.

Restrictions on annual limits

Prior to Jan. 1, 2014, group and individual health plans may only contain restricted annual limits on the dollar value of essential benefits. Annual limits for essential benefits are limited to:

- $750,000 for plan years beginning 9/23/2010 - 9/22/2011
- $1.25 million for plan years beginning 9/23/2011- 9/22/2012
- $2 million for plan years beginning 9/23/2012 – 12/31/2013

Essential benefits

The Secretary of HHS shall define the essential health benefits by federal regulation, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

HHS will take into account a plan or issuer's good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan or policy years beginning before the issuance of regulations defining the term. A plan or issuer must apply the definition of essential health benefits consistently.

Prohibition on rescissions

Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Notification must be made to policyholders prior to cancellation.

Coverage of preventive health services without cost-sharing

Plans must provide coverage without cost-sharing for:

- Services recommended by the U.S. Preventive Services Task Force

- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

Extension of adult dependent coverage

Plans that provide dependent coverage must extend coverage to adult children up to age 26. For plan years beginning before 2014, grandfathered group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage. PPACA does not require carriers to cover children of adult dependents.

Pre-existing condition exclusions

A plan may not impose any pre-existing condition exclusions for individuals age 19 and under. According to HHS, the term "pre-existing condition exclusion" applies to both a child's access to a plan and to his or her benefits once he or she is in the plan.

Patient protections

A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians and obstetrician/gynecologists.

Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.

A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat the authorization as the authorization of a primary care provider.

Appeals process

Under PPACA the Secretary of the U.S. Department of Health and Human Services and Secretary of the U.S. Department of Labor have established minimum standards for internal appeal and external review processes and will determine whether state standards meet or exceed those federal standards.

Provision of additional information

All plans must submit to the Secretary of HHS and the Director of the DIFP and make available to the public the following information in plain language:

- Claims payment policies and practices
- Periodic financial disclosures

- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to out-of-network coverage
- Information on enrollee and participant rights
- Other information as determined appropriate by the Secretary of HHS

DIFP review of PPACA health insurance filings

The DIFP will review health insurance filings on an EXPEDITED basis if:

- The filing is identified as a PPACA filing, pursuant to the SERFF filing requirement;
- An endorsement/amendment is filed to be used with previously approved forms;
- Only modifications relating to PPACA are included; and
- The filing includes a listing of the form numbers and approval dates of all previously approved forms that will be amended pursuant to the SERFF PPACA checklist.

Filings that include additional modifications and/or benefit changes not directly related to PPACA requirements cannot be given expedited review. Complete policy submissions will not be given expedited review.

Please be advised that whenever state laws are more favorable to the enrollee, federal requirements are to be considered a 'floor' for the application of benefits. State laws are not pre-empted whenever the application of state requirements does not impede the application of federal law.

If you have any questions regarding this communication, please contact Molly White in the Life and Healthcare Section at 573-526-4106 or Molly.White@insurance.mo.gov.